DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

45th day 70th 3-10-19 4-4-19

PRINTED: 01/25/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER NHC PLACE SUMMER STREET ADDRESS, CITY, STATE, ZIP CODE 140 THORNE BOULEVARD GALLATIN, TN 37066 PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE TAG INITIAL COMMENTS. A recertification survey was completed on 1/24/19 at NHC Place Summer. Deficiencies were oited under 42 CFR. PART 483, Requirements for Long Term Care Facilities. F 638 Qrtly Assessment at Least Every 3 Months CFF(s): 483.20(c) CFF(s): 483.20(c) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to complete a Quarterly Minimum Data Set (MDS) for 1 (#10) of 32 residents reviewed. The findings include: Medical record review revealed Resident #10 was admitted to the facility on 2/23/18 with diagnoses included Benign Neoplasm of Mentinges, Nontraumatic Intracranial Hemorrhage, and Toxic Encephalopathy. Medical record review revealed Resident #10 had STREET ADDRESS, CITY, STATE, ZIP CODE 140 THORNE BOULEVARD GALLATIN, TN 37066 PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE CRACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE CRACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE CRACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE 10 CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE CRACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE CRACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE CRACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE CRACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE TAG 1. Center completed quarterly assessment to residents and all assessments required by RAI guidelines. 2. A 100% audit was completed on 2/5/2019 with no other residents found to have missing	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
NHC PLACE SUMNER (X4) ID SUMMARY STATEMENT OF DEPOLENCIES PREFIX TAG. SUMMARY STATEMENT OF DEPOLENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS A recertification survey was completed on 1/24/19 at NHC Place Sumner. Deficiencles were cited under 42 CFR. PART 483, Requirements for Long Term Care Facilities. F 638 Qrtly Assessment at Least Every 3 Months SS=D CFR(s): 483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to complete a Quarterly Minimum Data Set (MDS) for 1 (#10) of 32 residents reviewed. The findings include: Medical record review revealed Resident #10 was admitted to the facility on 2/23/15 with diagnoses included Benign Neoplasm of Mentinges, Nontraumatic Intracranial Hemorrhage, and Toxic Encephalopathy. Medical record review revealed Resident #10 had 140 THORNE BOULEVARD GALLATIN, TN 37066 CROSS-REFERINCOR SHOULD BE CROSS-REFERINCE TO NEAPPROPRIATE OR PREFIX TAG PROVIDENT PROVIDENT NOT ABOULD BE CROSS-REFERINCE TON SHOULD BE CROSS-REFERINCE TON SH	PU	(#1	445519	B. WING			01/24	/2019
F 000 INITIAL COMMENTS A recertification survey was completed on 1/24/19 at NHC Place Sumner. Deficiencies were cited under 42 CFR. PART 483, Requirements for Long Term Care Pacilities. F 638 Crly Assessment at Least Every 3 Months SS=D CFR(s): 483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to complete a Quarterly Minimum Data Set (MDS) for 1 (#10) of 32 residents reviewed. The findings include: Medical record review revealed Resident #10 was admitted to the facility on 2/23/18 with diagnoses included Benign Neoplasm of Meninges, Nontraumatic Intraoranial Hemorrhage, and Toxic Encephalopathy. Medical record review revealed Resident #10 had	8. 3				140	THORNE BOULEVARD ALLATIN, TN 37066		
A recertification survey was completed on 1/24/19 at NHC Place Summer. Deficiencles were cited under 42 CFR PART 483, Requirements for Long Term Care Facilities. F 638. Grtly Assessment at Least Every 3 Months SS=D CFR(s): 483.20(c) \$483.20(c) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to complete a Quarterly Minimum Data Set (MDS) for 1 (#10) of 32 residents reviewed. The findings include: Medical record review revealed Resident #10 was admitted to the facility on 2/23/18 with diagnoses included Benign Neoplasm of Mentinges, Nontraumatic Intraoranial Hemorrhage, and Toxic Encephalopathy. Medical record review revealed Resident #10 had	PREFIX	(EACH DEFICIENT	CY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
Change MDS dated 9/27/18, Further medical. record review revealed no Quarterly MDS was randomly. The results will be reported to December 2018 through the QA process monthly by the DON	F 638	A recertification is 1/24/19 at NHC Picited under 42 CF Long Term Care I Qrtly Assessment CFR(s): 483.20(c) S483.20(c) Quart A facility must assigned underly review in and approved by once every 3 more This REQUIREM by: Based on medicate facility failed it Minimum Data Scresidents reviews The findings included Benigh Nontraumatic Intercephalopathy. Medical record readmitted to the facility ded Benigh Nontraumatic Intercephalopathy. Medical record readmitted to the facility MDS Change MDS date record review record record review record record record review record recor	urvey was completed on lace Sumner. Deficiencies were R. PART 483, Requirements for Facilities, at Least Every 3 Months. erly Review Assessment assurement specified by the State CMS not less frequently than on this. ENT is not met as evidenced at record review and interview, o complete a Quarterly et (MDS) for 1 (#10) of 32 ed. eview revealed Resident #10 was acility on 2/23/18 with diagnoses Neoplasm of Meninges, racranial Hemorrhage, and Toxic eview revealed Resident #10 had dated 8/24/18 and a Significant ted 9/27/18. Further medical yealed no Quarterly MDS was	L:		for resident #10 with ARD of 1/22/2019 ensure resident had all assessments reby RAI guidelines. 2. A 100% audit was completed on 2/5 for all inhouse residents as of 1/22/201 no other residents found to have missin assessments based on quarterly review instrument specified by the state and approved by CMS. 3. All MDS nurses were educated by the DON on 2/5/2019 that a quarterly assessment must have an ARD of previous assessment of any type plus no more that days, must be completed within 14 day ARD, and transmitted no later than 14 from completion date. 4. Monitoring includes residents with a length of stay 90 days or greater to ensitimeliness of quarterly assessment per guidelines and will include: weekly more of all assessments for 4 weeks, then biweekly monitoring for 2 weeks, then randomly. The results will be reported through the QA process monthly by the	he vious than 92 ys of days a sure r RAI nitoring	2/8/19
Interview with Registered Nurse (RN) #1 on 1/23/19 at 4:20 PM in her office revealed Resident #10 did not have a Quarterly MDS completed in December 2018. RN #1 stated		1/23/19 at 4:20 F	PM in her office revealed I not have a Quarterly MDS				TOT THE	
	in the sales	1000	/	CNATURE		TYTLE		(X8) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation. program participation.

FORM CMS-2567 (02-99) Previous Versions Obsolete

Event ID: BUEQ11

Facility ID: TN8308

If continuation sheet Page 1 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DELIVORED		A. BUILDING	COMPLETED		
		445519	B, WING	The second secon	01/24/2019
	TEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	14	REET ADDRESS, CITY, STATE, ZIP CODE 10 THORNE BOULEVARD ALLATIN, TN 37066 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D.BE COMPCETION
F 641	and I feel like I just Accuracy of Asses CFR(s): 483.20(g) S483.20(g) Accuration the assessment resident's status. This REQUIREMED by: Based on medical investigation, and accurately assess residents reviewed. The findings incluing Medical record readmitted to the faincluded Urinary Breath, and Falling discharged to the readmitted to the Resident #21 had Review of the factive aled Resider staff present assist Further review resulting from the Medical record redated 12/29/18 for the	Is was due in December 2018 It missed it." Isments Icy of Assessments. Inust accurately reflect the ENT is not met as evidenced If record review, review of facility interview, the facility failed to 2 (#21 and #68) of 32 d. Ice: Inust revealed Resident #21 was cility on 12/13/17 with diagnoses fract infection, Shortness of g. The resident had been hospital on 12/29/18 and facility on 1/4/19. Inustrial inustrial inustrial incomplete in the Quarterly Minimum lated 11/15/18 revealed in falls. Inustrial inustr		1. For resident #21 the inacce coding of MDS pertaining to for discharge destination were corrected. MDS assessment ARD of 12/29/2018 was corrected on 1/24/2019 and MDS with A 1/11/2019 was corrected on 1/29/2019. For resident #68 the discharge with ARD 12/11/2018 and inacceding of discharge destination corrected on 1/29/2019. 2. 100% audit of all MDS assessments in regards to acceding of falls and discharge destination, will a look backed days prior to 1/22/2019, was conducted. The Audit reveal of the 49 residents identified falls, 9 residents were identified falls, 9 residents were identified falls, 9 residents with errors coding of the discharge dest All corrections will be made 1/2/7/19.	with ected ARD ge MDS accurate on was 2/8/19 accurate of 90 ed out with fied with fout of s in ination.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			SURVEY		
		445519	B. WING		Charles and the second	24/2019	
	PROVIDER OR SUPPLIER	Laurence y and an address of the second	14	REET ADDRESS, CITY, STATE, ZIP CO D. THORNE BOULEVARD ALLATIN, TN 37066	DOC		
(X4) ID PREFIX TAG	TEACH DEFICIENC	AYEMENT OF DEFICIENCIES Y MUST BE PRÉCEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE.	(X5) COMPLETION DATE	
F 641	MDS dated 1/11/19 fall with injury since prior assessment. Interview with Reg responsible for the in the conference investigations, who falled to accurately 12/20/18, the RN sasked if the 1/11/1 12/20/18 fall the R fall would be on the interview with the conference room 1/11/19 MDS's "" Medical record readmitted to the fad discharged to the services on 12/11/18 with 1 Therapy], OT [Or nursing" Medical record readischarger possession 12/11/18 with 1 Therapy], OT [Or nursing"	iew of the Admission 5 day 2 revealed Resident #21 had 1 e admission/entry or reentry or istered Nurse (RN) #1, 2 MDS, on 1/24/19 at 9:35 AM room, after reviewing the facility en asked if the 12/29/18 MDS y assess Resident #21's fall on stated "Yes." When the RN was 9 MDS was to identify the N stated "No, the 12/20/18 e 12/29/18 MDS" Further RN at 11:35 AM in the confirmed the 12/29/18 and the were not correctly coded for view revealed Resident #68 was cility on 11/10/18 and community with home health		3. All MDS nurses were ethe DON on the accurate of and discharge destination guidelines on 2/5/2019. 4. Ongoing monitoring will monitoring of all MDS assaccuracy of coding of falls discharge monitoring. Most be completed by the DON designee weekly for 4 were for 2 weeks, then random results will be reported the process monthly by the D months and then at the distribution.	ooding of falls a per the RAI Il include essments for and initoring will or her eks, biweekly ly. The rough the QA ON for 2	2/8/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/24/2019			
		445519	William Control of the Control of th					
	PROVIDER OR SUPPLIES		STREET ADDRESS, CITY, STATE, ZIP CODE 140 THORNE BOULEVARD GALLATIN, TN 37066					
(X4) ID PREFIX TAG	LEACH DEFICIEN	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL GROSS-REFERENCED TO THE APPROI DEPICIENCY)	D.BE COMPLETION			
F 655	at 5:55 PM in the 12/11/18 discharge status discharge status with RN 1/24/19 at 6:10 P confirmed the disfailed to accurate as a community Baseline Care Pl CFR(s): 483.21(a) \$483.21(a) Base \$483.21(a)(1) Thimplement a base that includes the effective and per that meet profes The baseline call (i) Be developed admission. (ii) Include the meessary to profincluding, but no (A) Initial goals to (B) Physician or (C) Dietary order (E) Social service (F) PASARR received.	Director of Nursing on 1/24/19 conference room confirmed the ge MDS was not accurate for the to an acute hospital. If 1, responsible for the MDS, on M in the conference room charge MDS dated 12/11/18 ly identify the discharge status discharge. an (1)-(3) hensive Person-Centered Care line Care Plans are facility must develop and eline care plan for each resident instructions needed to provide son-centered care of the resident signal standards of quality care, within 48 hours of a resident's confirmum healthcare information operly care for a resident timited to-based on admission orders. In the facility may develop a second and the facility may develop a		1. For resident #50 admitted 12/6/2018, baseline care pla put in place on 12/9/2018. 2. 100% audit was conducted all residents inhouse on 1/22 to ensure baseline care pland in place. The audit revealed 10 residents out of 87 did not baseline care plans initiated Since 1/22/2019 to 2/5/2019 baseline care plans have be completed within 48 hours. 3. Admission nurse, unit may and charge nurses will be educated per the DON on all residents having a baseline plan in place within 48 hours admit. Education will be completed by 2/8/2019.	ed for 2/2019 s were that ot have timely. , all en nagers,			
1	comprehensive	care plan in place of the baseline	EI Ti					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		FICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E-CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	PROVIDER OR SUPPLIER	445519	STREET ADDRESS, CITY, STATE, ZIP CODE 140 THORNE BOULEVARD GALLATIN, TN 37066					
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE		
F 655	(i) Is developed wadmission. (ii) Meets the requision this section this section. §483.21(a)(3) The resident and their of the baseline callimited to: (i) The initial goal (ii) A summary of dietary instruction (iii) Any services administered by the on behalf of the folion of the compreher This REQUIREM by: Based on facility review and interview and int	mprehensive care plan- within 48 hours of the resident's direments set forth in paragraph (excepting paragraph (b)(2)(l) of e facility must provide the representative with a summary re plan that includes but is not als of the resident. If the resident's medications and and treatments to be the facility and personnel acting acility. Information based on the details asive care plan, as necessary. ENT is not met as evidenced policy review, medical record jew, the facility failed to have a in adressing falls for 1 (#50) of ewed. Littly policy, Care Plan ted 7/3/08 revealed "Interim in 48 hours of admission mmediate needs of the patient eview revealed Resident #50 wa acility on 12/6/18 with diagnoses and Disorders of the Brain, evariation, Muscle Weakness	80	4. Ongoing monitoring we review of all new admission nurse or unit rewithin 48 hours of admit baseline care plans are of timely. Weekly monitoring baseline care plans will the for 4 weeks, then biweek weeks, then randomly performed through the QA monthly by the DON for and then at the discretion committee.	ons per the manager ensuring completed of all ake place sly for 2 er the DON sults will be process 2 months	2/8/19		
			i	English ID: TN8308	If continuation	sheet Page 5		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEFALL	O COD MEDICADE	A MEDICAID SERVICES			The same of the sa	. 0938-0391	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULY A. BUILDI	IPLE CONSTRUCTION 10	(X3) DAT	(X3) DATE SURVEY COMPLETED		
		B WING			/24/2019		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 140 THORNE BOULEVARD GALLATIN, TN 37066	CODE		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C	HE APPROPRIATE	(X5) COMPLETION DATE	
	Continued From p Medical record rev 12/6/18 revealed t updated on 12/9/1 Interview with the 1/24/19 at 5:51 PM confirmed "the t admission proces 48 hours" Furthing	age 5 View of the care plan dated he baseline care plan was	F 6	355			
	1			1	مراخ مرسوس المراخ	n.sheet Page 8	
8.32	8	- un 91	IEO11	Facility ID: TN8308	if continuatio	Highlast Leda o	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED			
		445519	B. WING				01/2	01/24/2019	
NAME OF PROVIDER OR SUPPLIER NHC PLACE SUMNER				STREET ADDRESS, CITY, STATE, ZIP CODE 140 THORNE BOULEVARD GALLATIN, TN 37066					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
E 000	Initial Comments		E	000					
	completed 1/22/19	paredness survey was to 1/24/19 at NHC Place encies were cited under							
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		/Tytle /			(X6) DATE	

Any deficiency statement ending with an asterisk (1) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.